# Why International Relations and Global Public Health Need Each Other

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*Abstract*

The current COVID-19 global pandemic presents a clear illustration of the need for greater engagement between political science and international relations on the one hand and global health on the other. While this outbreak is the most high-profile example of the need for engagement between international relations and global health, it is far from the only one. It is impossible to understand the policy responses (or lack thereof) to HIV/AIDS, SARS, and H1N1 influenza, among others, without appreciating the political, social, and economic contexts in which these outbreaks occur and interact. Rather than offering a single vision for how this intellectual and academic engagement should occur, we present a number of potential avenues for engagement between the international relations theory and global health literatures and demonstrate why increased cross-fertilization between these literatures would both be academically enriching and improve our understanding of national and global policy processes. A stronger engagement between international relations and global health reminds us that health is inherently political and social, meaning that effectively understanding disease outbreaks and the policy responses to them necessarily goes beyond an understanding of biological sciences.

## Introduction

This is an essay born of frustration. As researchers who focus on global health politics as a subsection within the discipline(s) of political science and international relations, we share the view that there exist numerous fruitful exchanges between the ideas that exist within the larger international relations/comparative politics literatures and global health politics. International relations and comparative politics can (and should) inform research in global health politics. Equally important, though, is the idea that global health politics can (and should) inform the underlying theories of comparative politics and international relations. Theory is not and should not be a static, one-way street; it should be dynamic in the sense that it can incorporate and adapt to new information. In much the same way that Dunn and Shaw's (2001) edited volume demonstrates how the realities of African politics can and should inform international relations, we want to make a similar call for a more meaningful engagement between international relations theory and global health politics.

While we have long advocated for increased substantive engagement between international relations and global public health, recent events have brought the world's attention to the political nature of disease. We cannot fully understand or appreciate the dynamics of the policy responses (or lack thereof) to widespread disease outbreaks like SARS, H1N1 influenza, and COVID-19 without appreciating how the political, economic, and social contexts in which these diseases emerged colors how national and international actors have responded. Health is inherently political, and meaningful global public health policies need more than just a natural scientific understanding of a particular virus in order to move forward.

Because of this paper's genesis, we proceed less by laying out an argument and then "testing" it in some empirical way. Instead, we present instead some possible avenues for fruitful

mutual engagement between two research agendas that have hardly acknowledged one another. Our aim is not to suggest that there exists only one "right" lens for analyzing global health, nor do we suggest that we necessarily have the "answers" for understanding the relationship between the two fields. Not only would such an answer-oriented approach be incredibly premature, but the authors themselves do not entirely share a common IR theoretical orientation. Instead, we aim to call attention to issues in global health politics research where a closer engagement with international relations theory may prove beneficial—and where the insights of global health politics may provide new insights that can shape international relations theory.

Global health analysts who approach the field from a social scientific perspective, particularly those coming from an international relations background, can find a number of ways in which a more theoretically informed perspective would be beneficial. Theorists have at least considered a range of the ideas, concerns, and problems that are fundamental to examining global health as a political phenomenon—even if they have not figured out all of the answers.

Health scholars can profit from engagement with IR theory because the effects of some of the phenomena that we study have had important (if short of determinative) effects in prime concerns of IR theory (Paxton and Youde 2019). Theory might also provide us with avenues for considering *how* and *why* those very phenomena gain political salience. Rudolf Virchow, the German founder of social medicine, wrote in 1848, "Medicine is a social science, and politics is nothing but medicine on a grand scale" (cited in Taylor and Rieger 1985: 548), and an engagement with IR theory reinforces this notion and reminds us that *disease is inherently political and social*. Further, historically-oriented and -based international political theory (see, for example, Spruyt 1994 and Waltz 1959; for an overview of historical theories of international relations, see MacKay and LaRoche 2019) has long considered the ways in which "big"

processes have engaged and altered the state writ large. We can also see this level of engagement in some of the histories that take a long view (see, for example, McNeill 1998), but similar efforts connecting IR theory and global health remain fairly rare—to the detriment of both fields. It is vital that this gap be addressed, and we would like to propose an agenda.

We draw attention to four key issues in which a tighter connection between the literatures on global health politics and international relations theory could prove mutually beneficial:

- the place of the nation-state as a unit of analysis;
- the types of actors at work in the international realm;
- the "outsourcing" of traditional state functions to private actors; and
- the dilemmas posed by securitization.

Again, our aim in this paper is not to come up with definitive answers; rather, we want to highlight some key ways in which international relations and global public health need each other in order to produce meaningful analyses. The fact that we are writing this paper in the midst of the HIV and COVID-19 global pandemics means that we lack some final answers, but it also provides us with an opportunity to intervene in these policy and academic debates as they are contemporaneously raging.

**Nation-states as a unit of analysis**

The *ne plus ultra* of international relations and comparative politics lives in the development of the state and its attending transformations over the course of years from the Renaissance to the present day. While Charles Tilly claimed that "the state made war, and war made the state" (Tilly and Ardant 1975, 42), it has never been sufficient to be that simple or unicausal (a point with which we think Tilly would agree). Among other factors, the

depredations of disease have provided governments with the "excuse" to extend their authority, whether to protect the body of the king or to provide for the welfare of the polity's citizens. David Baldwin's foundational work on the definition and redefinition of security argues that states can and will sacrifice other values in the name of security. Instead of being a simple dichotomous variable, Baldwin argues that what a state secures reflects its larger values and priorities given that there is a limit to how much any single state can accomplish on its own (Baldwin 1997, 19–22).

We cannot understand the state—its origins, its historical development, its current extent—without connecting governance to the problem of protecting the ruler and ruled, and (eventually) the institutions of authority and citizens from epidemic disease events. There may also be some ways in which we can analogize between infectious disease outbreaks and war. Hatcher, Dick, and Dunn (2012) liken the emergence of an infectious disease in the human population to an invasion by a foreign army. They cite similarities in the effects that demographic and anthropogenic changes can have in driving 'invasions;' both have significant economic, social, and ecological costs, threaten human health, undermine food security, and can pose long-term societal and political challenges. At the same time, though, they also caution that there exist significant differences between the two concepts, particularly when it comes to examining the processes of co-evolution and how they may affect the likelihood of the invader taking root and establishing itself within the new population.

For all of the talk about the decreasing importance of the traditional, sovereign state, it is hardly dead. As the recent crises of Ebola and COVID-19 have pointed up, the state often remains the final policy arbiter of what occurs within its borders, which affects the course of local, national, and regional epidemics more than the causal pathogen. Even in a globalized

world with a broader array of governance patterns that cross national borders, the traditional Westphalian state retains primary responsibility for protecting and promoting the health of its subject-citizens.

Historically, the sovereign polity has borne the sole responsibility for managing disease infection. The quarantine itself derives from the *quarentara* period of isolation that the Rector of Ragusa (Dubrovnik) implemented in 1377 for land travelers coming to the trading port for commerce, a practice which eventually spread throughout a number of the Italian trading city-states. Ragusan authorities saw the process of quarantine as vital for protecting the "quality and safety of the trading network" (Gensini, Yacoub, and Conti 2004, 258), though Goodman notes that any successes associated with quarantine were "largely fortuitous" and that the policies allowed the state to direct actions against any group or polity that it saw as threatening (Goodman 1971, 34). Debates about the efficacy of quarantine persist to this day, with the World Health Organization largely arguing against travel restrictions, and national governments frequently resorting to them in the midst of cross-border disease crises.

From the beginning, the global governance of health was actually quite non-global. Each political unit ran its own policy to protect itself from disease, and the policy was primarily reactive in nature. Indeed, if we consider the nature of what we now think of as "global health," it is worth stepping back and considering its emergence as a medical discipline. "Global health" is, in actuality, the contemporary manifestation of what had previously been known as "colonial," "imperial," or "tropical" medicine (Pinto et al. 2013, 12). Birn acknowledges that the label "tropical" provided the dominant European states with "a way for imperial powers to define something culturally alien to, environmentally distinct from, and even threatening to Europe and other temperate regions" (Birn 2012, 43). This label implicitly "defined large portions of the

earth as zones of danger for Europeans" (Watson 2011, 163). In its contemporary expression, global health and its attendant security concerns have focused on "the protection of the West from threats emanating from the developing world" (Rushton 2011, 780). "Global," then, is a label or cover that obscures the fact that global health has largely embraced a unidirectional threat posture, with "strong" states (in the (Migdal 1988) sense of the term) getting concerned about the microbial threats they face from "weak" states.

In fact, the whole idea of a disease as something that the state[1] must defend itself against runs exactly parallel to the need to defend the realm militarily from the prevarications of other like units. The only real difference from the point of view of those who run the structure of governance is that the enemy-object is different: in one case, an enemy that can be seen, addressed, negotiated with; in the other, invisible, mysterious, but similarly calamitous. While isolationism was one possible response for state-to-state relations, it was pretty much the only option for state-to-disease responses.

In the end, in a world of anarchy, the state makes the final decision about who to allow to operate within its borders, whether to notify other actors about situations affecting the health of its citizens (although the most recent round of the IHR has weakened this somewhat, given that it allows other actors to report), and for good or ill, the decisions about cooperation or isolation with respect to health crises lie with the state. That said, in the arena of health, as in the diplomatic and conflict arenas, the state shows some capacity for learning over time. Witness the Chinese reaction to SARS (Huang 2003), and compare it to the alliance policies that states have engaged in. (Reiter (1994), for example, showed that states engaged in learning processes

[1] A term we use mostly as a substitute for the word "polity" and which we do not use to exclude the variety of forms we see in late medieval and early modern Europe (Spruyt 1994).

between the two world wars, changing their alliance strategies, depending on whether those each state pursued in WWI "worked" or not.) The Chinese strategy of self-help, obfuscation, and stonewalling the WHO, UN, CDC, and international community backfired, and after the resolution of the SARS mess, the Chinese moved to a policy of greater cooperation with the "international' community" on communicable diseases like HIV and various influenza forms. At the same time, learning processes within international relations are imperfect at best and can operate in unpredictable ways. One of the biggest debates that took place as the Ebola epidemic in West Africa wound down was how and whether the international community had learned anything about how to respond better in the future (as examples, see Hodge et al. 2014; Leach 2015; McInnes 2015; Smith and Upshur 2015; Woolhouse, Rambaut, and Kellam 2015)—but many of these discussions thus far have focused on the practical policy implications and avoided deeper engagement with the underlying theoretical bases or had not significantly interacted with the international relations theory literature. Similarly, the Chinese government has come under international pressure and condemnation for its failures to share timely and accurate COVID-19 data with the World Health Organization; indeed, this was one of the key complaints that led the Trump Administration to withdraw the United States from the organization.

International relations theory, whether coming from the American academy or elsewhere, has traditionally privileged and concentrated its attention on the state. This is not to say that international relations theory is silent about other sorts of actors (nor are we necessarily arguing that IR theory should have a state-centric focus), but the historical development of international relations theory has taken its primary purpose as engaging the state with its like and with the other actors that have arisen in response to the state. Regardless of various analytical proclivities, the fact remains that in times of crisis, we look to the state to react to health events and

epidemics. We assess the successes or failures of the state to implement an effective response to the health challenges facing the polity in a way that we do not hold other non-state actors accountable. We have a normative expectation that the state should mobilize its resources in the face of a pressing health crisis almost in manners similar to how it would respond to a military or diplomatic crisis.

International trade has driven the spread of contagious diseases, which has affected the interactions between/among states (Harrison 2013). That contagious disease spread has in turn affected the ways that states have chosen to interact with one another (the second concern of IR theory after the state itself). In fact, the ability of the state to conduct its internal and external economic policies (taxation and trade prime among them) has been a prime concern not only of the interactional aspect of IR theory but even of the origins of the sovereign form of the state (Spruyt 1994).

Sovereignty, as a/the governing norm of international politics, remains problematic in many areas of the world, and problematic sovereignty often overlaps with areas where health (especially as affected by infectious disease) is also problematic. Witness the responses to the Ebola outbreak. If we take sovereignty to mean that states have a positive obligation to provide some measure of services and support to their citizens (Jackson 1990, 29), then one of the biggest issues that helped give rise to the epidemic's spread was the state's lack of reach in most parts of the most afflicted states. This seemingly confirms Herbst's (2000; 2001) arguments about the nature of state control and ability to project power in African states and Spruyt's (2002) contentions about the changing nature of territorial sovereignty and its continued relevance as an underlying basis for international relations in the modern era. That said, we cannot abstract these conditions of weak sovereignty and weak power projection from their

larger historical and contemporary international political economy contexts (Benton and Dionne 2015). It may give greater urgency to arguments about the nature and origins of sovereign transfers and "incomplete transfers" as tools for how and under what conditions states offload some of their traditional sovereign responsibilities (Cooley and Spruyt 2009).

**Actor Types**

Theory and global health could certainly pay more attention to one another in regard to another classic question of international relations: the form and basis of actor types. At its core, it deals with the nature of sovereignty, legitimacy, and the relationship of actors to structures.

New forms of actors have come about or at least come into much greater international prominence due to global health. Primary among them is the transnational/international public-private partnership. Similar in form to PPPs on the domestic level, the T/I-PPP seeks to harness the efficiency gains of private, market-based organizations with the accountability and transparency of public governance (Balcius and Novotny 2011). In this way, they represent both a new actor in global health (and, by extension, international relations) and a new mode of governance itself. Because of this, they have been the subject of an increasing amount of scrutiny in terms of their form, their function, and their place within the larger universe of political actors (see, for example, Moran 2011; Ng and Ruger 2011; Ruckert and Labonté 2014).

The most prominent and developed of these organizations is the Global Fund to Fight AIDS, Tuberculosis, and Malaria (often shortened to Global Fund). The Global Fund is an amalgam of different types of previously existing organizations: international organization, non-profit charity, social enterprise business, and advocacy organization. It self-describes as "a broad stakeholder partnership [that] came together to design this new funding channel: governments,

civil society, the private sector, affected communities, development agencies and United Nations (UN) technical agencies" (Global Fund to Fight AIDS, Tuberculosis, and Malaria 2014).

Given the (mostly) triumph of the liberal market model of economic globalization, the PPP model is unlikely to disappear or reduce in importance. It is attractive to states both for the additional resources and expertise such partnerships can bring to bear in addressing the complex nature of global health and also because it offers governments a sense of plausible deniability and separation if problems arise.[2] PPPs provide a sense that governments are doing *something* to address global health, but allow them to do so without getting their hands too dirty. What remains particularly ambiguous is the nature of their authority. Under what auspices do PPPs possess a degree of legitimacy? Is their authority derived from delegation by states? If so, do states have the ability and authority to withdraw that legitimacy if the need arises or situations change? Questions about the nature and contours of private authority in global governance have become more prominent in recent years (Bexell and Mörth 2010; Hall and Biersteker 2002), and they are particularly important when it comes to health (see, for example, Harman 2016).

Unsurprisingly, the main theoretical traditions under examination here take very different approaches to understanding the role of non-state actors within international politics. Realists ascribe non-state actors the least status. Mearsheimer explicitly states that non-state actors have no role in realism because realism is a theory of state behavior and international relations is fundamentally about states. While he acknowledges that this means that the theory cannot capture every dynamic that happens in international relations, he says that no theory can explain

[2] For example, early U.S. federal responses to the WHO's actions in the COVID-19 crisis have included calls for an infectious disease "challenge fund" similar in style to the Global Fund, as well as to join a transnational PPP, the Coalition for Epidemic Preparedness Innovation.

everything. He does not deny that non-state actors exist; rather, he qualifies that non-state actors operate within a system of states and are reacting to that system. Therefore, understanding the action of non-state actors is fundamentally about understanding what states do (and do not do) (Mearsheimer 2006). Intergovernmental organizations receive similar treatment in most of realism. Intergovernmental organizations, according to most realists, lack their own agency; rather, their existence and operation are a reflection of the interests of great powers (Gilpin 1981; Mearsheimer 1994).

Neoliberal institutionalists take a different approach. They allow for a wide and diverse range of roles for non-state actors. Intergovernmental organizations make international relations possible, as they provide forums for building interdependent ties among states and resolving disputes short of having to resort to violent means (Keohane and Nye 1977). The growing number of intergovernmental organizations and nongovernmental organizations and the broadening range of areas in which they work is proof, according to the neoliberal institutionalists, that non-state actors play a significant role in understanding international relations. As Milner (2009) pithily summarizes, "For neoliberal institutionalism, world politics is institutional" (6). Incorporating the wide range of actors into an understanding of international relations gives neoliberal institutionalism a "richness" that other theories lack (Milner 2009, 12). Non-state actors and intergovernmental organizations may not fundamentally transform states or their interests, but they make the business of international relations possible.

Constructivism expands the range of possibilities for non-state actors. The international system is created and re-created through the interactions of actors, and constructivism avoids analytically privileging any specific actor or group of actors. These interactions give rise to the norms, ideas, interests, and identities that shape the broad outlines of international politics. It is

precisely this emphasis on the mutability of interests that offers these non-state actors the opportunity to play significant roles in global politics. Non-state actors can try to change how states see themselves or how they act toward others, giving them transformative potential (Ahmed and Potter 2006, 48:14). If the international system consists of "shared knowledge, material resources, and practices" (Wendt 1995, 73), and constructivism does not start from the premise that states are the key international actor, then there is space in which non-state actors can shape international relations in decisive ways. This does not necessarily mean that non-state actors *will* or *must* play these roles; rather, the emphasis is on providing the analytical framework for understanding how non-state actors can significantly influence international relations. They can help give rise to the international standards and "soft law" by which we evaluate the appropriateness of actions and behaviors within the international system (Mertus 1999, 561).

**Private Actor "Outsourcing"**

As the most recent global health crises have shown, few international actors have a dedicated force that addresses outbreaks of infectious diseases with epidemic potential. Arguably, the only extant institution with the ability to respond rapidly and comprehensively in a variety of settings, including those outside its borders, is the U.S. Centers for Disease Control and Prevention (CDC), and its capacity has undergone a significant diminution in recent years. As most recently seen in the Ebola outbreak, the WHO cannot do much beyond sound an alert, and it may not have done even that very well most recently (Youde 2014). At the same time, WHO's ability to act more forcefully—to take the actions that members of the international community have criticized it for *not* undertaking—is hobbled by a number of institutional and budgetary constraints (Youde 2012, chap. 2). Member-states have the power to lift these

constraints, but they have shown little inclination to do so yet even in the midst of the COVID-19 pandemic (Zimmer 2020).

Global health response has been left to a catch-as-catch-can set of actors, not all of which are equipped or appropriate for engaging with public health. The West Africa Ebola epidemic of 2014 provides a typical example. Guinea, Liberia, and Sierra Leone—among the poorest countries in the world by virtually every measure—had inadequate medical and public health infrastructure of their own. As just one example, the *Washington Post* reported in October 2014 that Liberia's single medical college lacked running water until 2008, and the country was reported to have only about 50 practicing physicians (Sieff 2014). Medical services in Liberia, thus, came from a variety of outside groups, most prominently Médecins Sans Frontières/Doctors Without Borders (which "employed 4000 national staff and 325 expatriate staff" across the three most-affected countries [http://www.msf.org/diseases/ebola]). MSF thought that WHO should sound the alert on the disease outbreak, perhaps even sending physicians of its own to the affected states.[3] Eventually the two organizations ended up casting blame on each other a year after the epidemic broke out in West Africa (*The New Dawn* 2015). The CDC coordinated technical assistance and control activities along with sending public health professionals to the region. In October 2014, the United States began to send 4000 military personnel to Liberia, in

[3] MSF appeared unaware at the time that WHO has no such contingent of rapid response physicians. Probably the only organization that could have responded in the manner that MSF expected or wanted was the CDC's Epidemiological Intelligence Service, though some reform proposals for WHO have called for the creation of a rapid ready force of epidemiologists and public health workers from around the world who could be seconded from their governments and deployed quickly into emergency situations.

addition to the 900 other US government personnel working on the issue in West Africa (Salaam-Blyther 2014, ii–iii, 17–18). The United Kingdom sent roughly 750 troops to construct Ebola treatment units in Sierra Leone, and the African Union deployed another 720 civilian and military health workers to provide direct services in the affected countries (Kamradt-Scott 2016, 13–14). Workers from the International Red Cross/Red Crescent and other NGOs played roles in educating and assisting publics in West Africa and around the world. Thus, in this most recent major global health crisis prior to COVID-19, a broad range of actor types were involved: weak "developing" state governments; strong "developed" governments and their international civilian and military forces; international governmental organizations; medical/charitable NGOs; and activist NGOs (MSF has both medical/charitable and activist components).

Having global health challenges handled by a variety of actor types is hardly unusual in international relations in our era. Most areas of modern global politics have the engagement of several types of actors. Such is the sign of our globalized time and world. By and large, however, the management of global health has been largely left to WHO and NGOs like MSF. States either lack the capacity to manage their own public health; when they have capacity, they act for their own interest first and perhaps the global later. We have effectively outsourced much of day-to-day global health practice to private (or private-ish[4]) actors and hoped that they will be an adequate first line of protection against epidemic expansion. Despite this on-the-ground reality,

[4] "Private-ish" because while most of these actors like MSF, IRCRC, and so forth are not government or quasi-governmental organs, they act ostensibly in the public interest, according to the general humanitarian norms of the medical and helping professions. In low resource places like West Africa, these groups are pretty transparent that they stand-in for functions of official public health services in countries with greater resources.

though, the international community's notions of global health governance tend to focus largely on state or intergovernmental actors, leaving the inclusion of or consultation with other actors in an ambiguous limbo state.

The situation is analogous to that of the mercenaries that most polities made use of during the pre- and early modern era, as well as the increased use of para-mercenary forces in the recent conflicts in Iraq, Afghanistan, and Pakistan. Besides private *military* force, Abrahamsen and Williams (2011) explain how private security companies have expanded and consolidated into a global industry, with public police forces and private security contractors interpenetrating one another to provide suites of related services.

International relations theory has a long tradition of incorporating private sector actors who perform vital functions for the polity into its analyses. This has often taken the form of examining or worrying about the effects and effectiveness of mercenary military forces. Because it touches on the very ontology of the state—we are reminded here of Weber's conceptualization of the state as the organization that controls the monopoly of legitimate violence within a given territory—theorists have often worried about the "outsourcing" of that monopoly to contracted employees. But there is another strand of thought, focusing on a different aspect of the violence monopoly, that sees the outsourcing of "state function" as a mark of globalization's rebundling of the state. We will consider each of these two primary strands in turn, via the work of representative thinkers from each.

Niccolò Machiavelli archetypically represents the first strand of thinking about mercenaries. Mercenaries prove a danger to the state, for "[t]he chief foundation of all states…are good laws and good arms", and mercenaries are inherently unreliable arms. For Machiavelli, good arms secure good laws, such that there can be no "good" laws without force of

arms to back them, at least in the principality (Machiavelli 1513, chap. 12). In evocative language, Machiavelli argues that hired guns are

> *"…useless and dangerous; and if one holds his state based on these arms, he will stand neither firm nor safe; for they are disunited, ambitious, and without discipline, unfaithful, valiant before friends, cowardly before enemies; they have neither the fear of God nor fidelity to men, and destruction is deferred only so long as the attack is; for in peace one is robbed by them, and in war by the enemy" (Machiavelli 1513, chap. 12).*

Machiavelli expands on his reasoning in Book 2, Chapter 20 of *The Discourses*, calling such help "pernicious" because the master of the state lacks mastery of the agents hired to defend the polity. He distinguishes between mercenaries and "auxiliaries" ("those sent to your assistance by some other potentate"), and he seems even more distrustful of the latter than of the former (see also his comments on such in Chapter 13 of *The Prince*).

Political leaders often characterize the fight against infectious diseases as a "war" against microbes. Wars, of course, require militaries to fight them, and the idea that microbial diseases constitute a "threat" to be "fought" remains an exceedingly common one. Alex de Waal (2003, 2014) has pointed out that this conceptualization of health helps to tip the means of dealing with the challenge toward the military and the militarized. This makes it significantly easier to institute martial law, stigmatize the infected and their caretakers, divert resources from genuine public health measures to protection against putative bioterror, and strengthen the hands of anti-democratic forces and leaders in a society. Using the language of conflict and combat makes this more likely.

The management of global health, for many nations, has been largely outsourced. This is particularly true for the parts of the world where infectious diseases remain the greatest health

challenges and (by no coincidence) resources for health are lowest. For these countries, there is little control or management of the public health, making them subject to the "gracious" charity of others in the global system. Those others may or may not be working for the benefit of the people most affected.

For most of sub-Saharan Africa, the national public health situation resembles that of Liberia in 2014, in kind if not exactly in degree. "Brain drain" of physicians and researchers to the developed world most intensely affects the poorest countries (World Health Organization 2006). As a result, the monitoring and maintenance of public health relies upon outside actors to provide these services, and the level of oversight and accountability of these outside actors by national governments varies widely.

Sometimes these actors are private-sector in nature—akin to Machiavelli's mercenaries—and at other times the actors are the agents of another government— Machiavelli's "auxiliaries." We often assume that medically oriented actors will behave "better" than military mercenaries or auxiliaries, but on what basis do we grounded this assumption? History provides little reassurance that the medical professions will not act in "selfish" manner to benefit their own organizations or that of the states that send them. Indeed, the discipline of "tropical" medicine would at least provide cause for doubting that expatriate medical professionals in sub-Saharan Africa, India, Southeast Asia, or wherever act solely or primarily for the interest of their potential patients. This is not to say that contemporary physicians, nurses, and other medical personnel actively consider what their country or NGO "wants" with respect to any patient(s). But priorities must be balanced against one another, sending organizations or actors place limitations on professional and individual action, and few personnel become permanent, vested members of the societies in which they practice. Individual medical practitioners may well follow some

ethical standard of practice, such as the "Hippocratic oath", but organizational strictures, limitations, standard operating procedures, and identities mitigate, divert, and form the individual sense of opportunities and options.

Thus, rather than view medical or public health attention to resource-poor environments as a generally positive circumstance, international relations theory and history might remind us that where life or security (broadly understood) are at stake, there is reason to suspect the reliability of outside actors. These groups may be able to leverage certain advantages or resources, but they may also be fickle and of uncertain dependability.

The second strand of thinking about using private actors as a means of providing protection portrays a process of state "unbundling," deriving directly from the forces of globalization. Drawing on insights from Weber and Bourdieu, Abrahamsen and Williams (2011) argue that the portrayal of this realm as a contrast of oppositions—public versus private, global versus local—means that we will miss key characteristics of these actors and the systems in which they operate. To put it simply, the state is not necessarily weakened when it contracts out its security, safety, or welfare functions; instead, the state's power is reconfigured. "…[N]ew practices and forms of power that cannot be neatly contained within the geographical boundaries of the state" come into being, and "public" and "private" actors "interact in a field of tension, structured by the opposition between the public and the private and their different forms of material and symbolic power" (Abrahamsen and Williams 2011, 3).

By combining ideas associated with Saskia Sassen and Michel Foucault, this version of globalization becomes less about the withdrawal or dissolution of the modern nation-state. What we do see is nation-states responding to the logic of the political and economic structures they have created. States *disassemble* their own component structures and functions, they help private

actors to develop *capacity* to do those structures and functions on behalf of the state, and the private and public actors *reassemble* those functions into new actors and "assemblages"[5] that operate simultaneously at local and global levels (Abrahamsen and Williams 2011, 66, 90–91).

In this schema, the security of person and property in a modern society does not come exclusively from the public or the private sector. What we do see is police (the public manifestation of security and protection) and "security companies" (the private) providing different but interpenetrated aspects of the overall security assemblage. The person watching and controlling access to the door of the office building in which you work most likely works as a wage employee of a company like GardaWorld or Securitas AB. The official police are certainly available in case of major incident but are relieved from the personnel-intensive low-skill work of routine watching. Throw in that the private guard may well be an off-duty police officer earning extra income, and the lines between "public" and "private" security forces can blur and make it more sensible to speak of a security assemblage.

With this in mind, a large-scale health assemblage becomes visible. No such thing as a legitimate monopoly of welfare-provision exists. That is an ideal type in the same way that in the contemporary world the legitimate monopoly of violence is more of an ideal type (which may well be what Weber intended, at least if you buy the third, "analytic" argument of Jackson (2011)) than a description of reality. Not only in resource-poor countries but in resource-rich as well, the component of the general welfare encompassed by "health" uses a large number of different actor-types, configured for a particular time and place. Thus, in low-income countries, where the national government lacks the ability to provide or to oversee and supervise providing

[5] A particular temporal configuration of structures and practices involving multiple, different-type actors.

the "health good" (just as it might be unable to do so with the security good), other actors step in to do so.

For example, in Kenya, the national government partners with the United States Agency for International Development (USAID) to provide funding and program support for a variety of health initiatives,[6] involving HIV, nutrition, sports and health lifestyle education, and health systems strengthening. Looking at one program, the Handwashing Initiative,[7] the other partners include Colgate-Palmolive, Procter and Gamble, Unilever, UNICEF, the World Bank, and the London School of Hygiene and Tropical Medicine; the Academy of Educational Development provided implementation. Thus in this example, we see one national government partnering with another, in a bilateral aid relationship, as well as with three transnational corporations, two international organizations, and an academic institution, with a non-governmental, non-profit organization doing operations. In this particular project, we do not even see two increasingly common types of actors in providing and operating developing world health, private foundations (e.g., Gates, Kaiser, Robert Wood Johnson, Ford, Rockefeller, MacArthur, etc.) and research or consultancy operations (like PSI, FHI, John Snow, Accenture, RAND, Mathematica Policy Institute, Abt Associates, and so forth, some for- and others non-profit) that provide assistance in marketing, implementation, operations, and monitoring and evaluation. Nor do we see the variety of charitable civil society organizations—some faith based, others not—often found in these contexts, like Worldvision, Save the Children, or Partners in Health.

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[6] See United States Agency for International Development's Partnership Database, https://partnerships.usaid.gov (accessed 7 March 2016).

[7] https://partnerships.usaid.gov/partnership/handwashing-initiative

The complex of actors involved in the provision of health is varied, both public and private, profit-seeking and not, local and global. One of the best arenas in which to see this assemblage is at the biennial International AIDS Conference (which one of us used to attend with regularity). The sheer variety of involved actors staggers the mind—among the attendees in the exhibit hall in 2012 in Washington DC were: UNAIDS and the Global Fund; the French, German, Canadian, Ghanaian, Botswana, and Nigerian governments; Chevron, Merck, and Bristol-Meyers Squibb; Catholics for Choice and Saddleback Church; and a vast array of the United States government agencies (FDA, USAID, HHS, NIH, CDC, Census Bureau). In addition, there are scores of activist groups, some with official booths in the hall; one sees the Treatment Action Campaign, GMHC, and ACT-UP in plenary sessions and hallways. The roughly 20,000 participants are natural science and social science researchers, politicians, HIV activists, government bureaucrats, corporate employees, publishers, small entrepreneurs (from whom else will you buy your souvenir Zimbabwe $10 billion note?), and members of the international media.

All of this seeks to develop the capacity of private actors to take on functions, structures, and practices to manage and improve the general welfare as embodied in health. We have unbundled older structures and institutions, forged new combinations of public and private, and even created a discipline called “global health” (as a site of practice and field of study). We would do well to understand the mercenaries in our midst.

**The Securitization Dilemma**

Securitization theory, largely originated within the Copenhagen School of international relations theory, draws heavily on speech-act theory, which itself drew from J.L. Austin's (1962) and John Searle's (1969) works on philosophy of language.

Securitization theory argues that material capabilities in and of themselves do not determine whether something qualifies as a security issue. Instead, it argues that the ways in which actors frame and conceptualize an issue determine whether something rises to the level of a security issue. Understanding whether something becomes a security issue is thus about its linguistic representation rather than any *a priori* exogenous qualities. Furthermore, when an issue gets reframed as a security issue, that necessarily transforms the politics of that issue because policymakers tend to engage with security issues in fundamentally different ways. A security issue thus moves beyond the realm of normal politics and into the realm of "high politics." Debates about war lead to a different sort of immediacy and existential baggage that debates about agricultural policy simply do not possess (Youde 2016: 161).

Three elements are essential for the successful securitization of an issue. First, there must be an *actor* (which could be either an individual or a group). Second, that actor attempt to transform a *referent object* into a security issue. Third, there must be an audience that accepts the actor's argument and agrees that the referent object constitutes an existential threat to the state. This three-step process is important to understand because it recognizes that this is inherently a process and that it is itself a political act that may not necessarily succeed if the issue fails to resonate with the target audience (Buzan, Wæver, and Wilde 1998; Waever 1995; Williams 2003).

Particularly in the past 25 years, there have been various efforts to securitize global health. Some of these efforts have looked at global health writ large as a security issue, while others have focused on specific illnesses or diseases. An effort to securitize health implicitly suggests that there exists an actor who wants to securitize some element of global health; the question thus hinges on whether the target audience agrees that global health constitutes a "high politics" or security issue (Youde 2016). It requires the acceptance of a logic of exceptionalism that brings the risk and security logics together to drive policy actions (Kirk 2020).

The primary analytic category of security is "threat," and that implies that there are default and deviant states-of-being in the world. Traditionally in security studies, war or violent conflict serves as the deviation from some ideal state of non-conflict. Insofar as there is an agenda in security, it is that understanding the causes and consequences of violence will allow for the furtherance of conditions that will make less likely the violent conflict that kills soldier and civilian. In health securitization, the default state is assumed to be "health"—the absence of diseases and other conditions that constitutes threat to life and ability. Biologically, it is not clear that such a viewpoint makes sense (i.e., the organism is always under "attack" from pathogens, poisons, and probabilities). Socially it may not make sense either—as each disease or threat to health is "conquered", another arises to take its place, and there is no end state to the threat faced.

While securitizing health and framing it as a health concern may generate greater attention and more resources, such a move comes with its own baggage. McInnes and Rushton write, "What constitutes a 'health security' issues appears to be determined by something other

than a 'clear and present' danger to life" (2013, 116). It is this "something other" that can make securitizing health a difficult element of an effective disease surveillance system.

First, health security means different things to different audiences. There exists no universally agreed upon definition of health security. As such, the term itself can generate confusion and mistrust. Aldis notes that developing countries have raised concerns about the term, fearing that it could be used as a cover to justify unwelcome interventions (Aldis 2008, 370). Rushton contends that there are three common characteristics of health security definitions: a focus on *fast-moving pathogens that pose threats* to individuals and states; an emphasis on *pathogens that could be weaponized*; and a focus on *severe disease burdens* that could have social, political, economic, or military effects on a state or region (Rushton 2011, 780). Even among these similarities, though, he cautions that this shared language of health security "masks deep divisions in aims, methods, and values" (Rushton 2011, 779). Potentially weaponizable pathogens are but a small subset of infectious diseases, and they are far from the most pressing or common health problems facing the vast majority of people—either in the United States or around the world. Connecting health with its potential for negative effects on the state threatens to privilege a certain subset of diseases and does little to address endemic health concerns that have already depressed economic development or state performance. New diseases can certainly pose a substantial threat, but, as noted above, too much of a focus on the new, novel, and quick can distract attention from the more pressing health concerns. (Benson and Glasgow 2015) argue, for instance, that an emphasis on new infectious diseases as a security threat diverts attention from noncommunicable diseases, which cause far higher rates of morbidity and mortality than infectious diseases do. In the end, the ambiguity of how health security is defined

can lead to a situation in which health itself is subordinated to how powerful security interests interpret a given health concern.

Second, making health a security issue also transforms security itself. Security becomes medicalized, meaning that it gets interpreted using medical analogies and tying to craft a 'prescription' to solve the problem (Conrad 2007, 4). Elbe raises the concern specifically in the context of health and security:

> When the domains of health and security intersect, it does not just shape how particular diseases are governed in the international system; it similarly encourages changes to how security is understood, to how security is provided, and indeed who practices security in contemporary international relations (Elbe 2011, 848–49).

Elbe describes three interrelated processes that give rise to the medicalization of security: defining insecurity as a medical problem; giving medical professionals a greater role in politics; and attempting to secure populations through medical interventions (Elbe 2010, 23-29). In this way, disease surveillance systems explicitly built on a logic of security transform medical and public health professionals into security officers and shape the sorts of recommended interventions. Medical analogies might be helpful in some instances when it comes to security, but security problems rarely lend themselves to a single 'prescription' that can be used to 'treat' the problem.

Third, the connections between health and security are far more subtle than the rhetoric of security suggests. The causal pathway between a polity's security and a particular infectious disease or overall health can be difficult to trace. This is not to say that there exist no connections between health and security; rather, the connections that do exist are far more indirect and

diffuse than the emphasis on securitizing health would suggest (Paxton 2012: 148). In 2000, the United Nations Security Council historically chose to devote a special session solely to how HIV/AIDS posed threats to national and international security. It represented the first-ever instance of the Security Council designated a health concern a security threat, and it brought a great deal of attention to and resources for combatting HIV/AIDS. More than a decade out, though, evidence suggests that the consensus and action generated by this high-level attention appears overstated (de Waal 2010a; 2010b). As early as 2001, David suggested that designating HIV a security issue was wrongheaded because the UNSC's tools for addressing security threats were wholly inadequate and inappropriate to the challenges that the virus actually presented (David 2001). The linkages are far more complex, varied, and nuanced, but the language of security is too blunt an instrument to allow for appreciating the nuances. The language of security predisposes government officials to take certain kinds of responses, but those responses do not necessarily match up with what is needed on the ground. Indeed, they may raise new tensions (McInnes and Rushton 2010, 225–26). Disease outbreaks may generate scarcities and vulnerabilities, but those disease outbreaks are not necessarily related to security itself (Fischhendler and Katz 2013). An outbreak in the United States could lead to shortages of medical supplies and equipment or interrupt certain government and societal activities, but these may not be security concerns per se. While the COVID-19 pandemic does seem to be in the process of creating security problems for highly affected nations like the US, the security concern may be a second-order effect of supply shortages, service interruptions, and high morbidity and mortality.

Finally, the process of securitizing health (or any other issue, for that matter) suggests that the issue has left the realm of 'normal' politics. When a society transforms something into

a security issue or threat, it is implicitly and explicitly stating that the normal political realm is ill-equipped to handle the issue. Calling health a security issue casts the issue "as one of an 'existential threat,' which calls for extraordinary measures beyond the routines and norms of everyday politics" (Williams 2003, 514). Aradau (2004) argues that securitization is an inherently negative process because it prioritizes fast-track decisionmaking in order to respond to the immediacy of the threat; it thrives on creating and sustaining an 'Other' that is cast as the enemy or an outsider that cannot be tolerated. Such an environment is often inappropriate for addressing health issues. While there may be a need to implement short-term and immediate measures to address a disease outbreak, preventing epidemics and protecting against a bioterrorist attack requires long-term and carefully considered strategies. Because microbes can and do cross borders with remarkable ease, governments must by definition collaborate and cooperate in order to stop the spread of any disease; a biosurveillance strategy that focuses solely on the United States to the exclusion of the other parts of the world is short-sighted at best. That said, securitization's tendency toward dichotomization encourages policymakers to categorize countries as 'good' or 'bad,' 'healthy' or 'sick.' Such bifurcation could work directly in opposition to the need to build cooperative relationships with a wide variety of countries in an effort to keep Americans health. Furthermore, this dichotomization could trickle down to those who fall ill themselves. If the ill become seen as 'the enemy' or 'the other,' it can discourage them from coming forward to seek treatment, which imperils the greater population.

Despite these downsides to securitization, repeated experience demonstrates that states frequently rely on the military as a tool to address global health problems. The military can be used to engage in a wide variety of tasks: creating a *cordon sanitaire*, enforcing a quarantine, delivering services (either as a logistical agent or as a direct provider of treatment), forcibly

administering medical treatment, and conducting research into defense against biological attacks (which runs the risk of being used as a biological weapon itself; see (Enemark 2014)). The recent Ebola outbreak featured many of these elements. The Liberian military tried to enforce quarantine orders, which led to riots among the residents of the West Point neighborhood of Monrovia and soldiers firing live ammunition and beating residents (MacDougall 2015). Other countries like the United States, France, and China deployed their armed forces to build treatment centers and provide medical services (Kamradt-Scott et al. 2015). These efforts to securitize and militarize the response to Ebola generated much criticism (Huang 2014), but the fact remains that there has been a co-mingling of security and health. COVID-19, so far, appears to have intensified these trends.

It is important to remember that security's ultimate analytic category is "threat." A security issue is something that poses a threat to someone or some institution. Health—and not just infectious disease)—is almost always posed as a natural resting state in the same way that traditional security studies tends to posit peace as a natural resting state. In this framework, disease is an aberration from stasis, and that aberration is something that must be denied, fought, and conquered. Such a mindset lends itself easily to analogizing to other strategies to respond to threats.

**Conclusion**

As we write, the world is less than a year into the most fast-spreading and significant infectious disease outbreak since (at least) the 1918-19 influenza pandemic. COVID-19 will not be the last global pandemic. We do not know when, where, or what will cause the next global outbreak, but we know that infectious disease outbreaks that cross national borders and require

international cooperation to effectively address will definitely happen in the future. If we learn nothing else from this current outbreak and how various countries have successfully or unsuccessfully responded, it is that we need to understand the international political dimension if we want to fully appreciate how governments and governance structures have reacted. The lack of serious and sustained engagement between the literatures on global health politics and international relations theory has thus far hampered our ability to engage in this very necessary sort of analysis. Not only will engagement give us better analytical tools, but it will redound greatly to both fields. The examination of four pathways by which international relations theory can offer crucial insights for understanding global health and global health politics that we present in this article will—with luck—encourage more scholars to recognize the value in understanding these relationships. This is not just an academic exercise; as we now see day by day, this matters for people's lives. International relations scholars *can and should be* well-placed to help the global community respond to disease outbreaks and pandemics, and connecting international relations theory and global health more explicitly will increase our discipline's ability to respond.

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